

# NYS Answers to CMS Preliminary BH 1115 Amendment Questions

12/30/13

## New York State Section 1115 Demonstration Amendment (page 3)

### Introduction (page 3)

1. Discuss how this amendment impacts the current relationship between DOH and the State's prepaid mental health plan arrangement between OMH and the state psych hospitals?
  - a. Upon transition of the BH benefits to managed care, PMHP is only available for individuals not enrolled in MCOs (those remaining in FFS).
2. What will be the MCOs qualification difference? Will all MCOs be required to have a HARP line of business? What happens to a beneficiary who needs HARP, but the MCO doesn't have a HARP line of business.
  - a. Mainstream managed care Plans will need to demonstrate their qualifications to manage Medicaid behavioral health benefits. The proposed qualifications are identified in Section 3 of the attached draft RFQ.
  - b. Current Medicaid Managed Care Plans can apply to qualify for a HARP but, at this point, New York is not requiring all Plans to have a HARP line of business.
  - c. NY expects all Plans to qualify to manage the currently carved out State Plan Medicaid behavioral health services as part of the mainstream benefit for non-HARP eligibles. HARP plans will offer specialized care management for high needs populations with mental health and/or substance use diagnosis and access to additional home and community based services (1915(i)-like). If a beneficiary is enrolled in a Plan that does not offer a HARP, the beneficiary can stay where they are (but they will be notified that choice will restrict their access to 1915i services) or change to a Plan that offers a HARP. Once a member is identified as HARP eligible, they can enroll in a HARP at any point. Members will be given 90 days to opt out before they are auto-enrolled into the HARP.
3. What are the benefits that will be in the HARP? Who completes the screening for HARP enrollment?
  - a. The HARP will offer adults (21 and over) all of the physical health and pharmacy benefits currently found in mainstream Medicaid Plans in NYS. Additionally, HARPs will offer all of the behavioral health benefits listed in Tables 2 and 3 of the draft waiver (pages 10 and 17) including 1915i-like services.

- b. All individuals enrolled in the HARP will be enrolled in a Health Home, and will be assigned a Health Home care manager (or other qualified individual) who will initiate a person-centered planning process to determine an integrated plan of care. This will include the completion of an evaluation for home and community based 1915(i)-like services. Those determined eligible for 1915(i)-like services will receive a comprehensive assessment using the interRAI assessment scale. This process will comply with federal conflict-free case management requirements.
4. Confirm that the HH mentioned here enrolled state plan providers and are conducting care management and planning? Does NY have any proposed amendments needed for health home state plan authority?
- a. The Health Homes referred to in the 1115 waiver are those that are reimbursed by Medicaid under the State's approved Medicaid Plan.
  - b. While alternative rates are being developed, NYS plans to submit a Health Home State Plan Amendment that will continue to reimburse converted Targeted Case Management (TCM) providers at their existing Health Home legacy rates through December 31, 2014. The proposed effective date is January 1, 2014.
5. Is there a future plan for the children's BH services?
- a. Yes, NYS is developing a plan for moving children's behavioral health services into managed care. This plan is about one year later than the plan for adults. As mentioned on page 5 of the draft waiver amendment request, the anticipated implementation date for children is January 2016.
  - b. However, starting in 2015, Plans will be expected to provide behavioral health transition planning to ensure continuity of care for youth until age 23 or until the youth is stabilized in the adult system, whichever is later. MCOs must ensure that children who utilize BH programs and HCBS waivers from both OMH or the Office of Children and Family Services are screened for entry into a HARP and are transitioned to a HARP if that is the individual's choice.
  - c. MCOs will also need to provide the full range of medically necessary Medicaid services for members who have a first onset of psychosis. Individuals identified as having "First Episode Psychosis" (FEP) will be enrolled in HARPs (if that is their choice) and be eligible for 1915(i)-like services through the HARP.
6. Please provide additional details regarding the new behavioral health specific administrative and fiscal standards that the Managed Care Organizations (MCOs) have to meet in order to meet.

- a. The behavioral health administrative and fiscal standards are identified in the attached draft RFQ in section 3. Staffing standards can be found in section 3.3. Network requirements are in Sections 3.5 and 3.6. Utilization management and clinical management are sections 3.9 and 3.10 respectively. Fiscal standards are identified 3.14, 3.16 and 3.17. The goal is to assure that plans responsibly manage the behavioral health services and that they develop capabilities to move from a primarily medical management focus to a recovery support capacity as well. We would be happy to answer any specific questions on anything in these sections.
7. Could we see plan evaluation criteria? Has the state ascertained the MCOs corporate history and experience with BH and SUD in other markets? Are MCOs allowed to subcontract with a BH PIHP?
- a. This is a draft waiver amendment and the attached RFQ is part of a request for information that is currently out for stakeholder input. The State is currently working on evaluation criteria. However, this is not a competitive bid. All Plans can qualify to manage the behavioral health services and all Plans can qualify to operate a HARP.
  - b. As part of the qualifications process, Plans will need to demonstrate experience and qualifications to manage BH services.
  - c. At this time, NYS does not have any BH PIHPs.

**Background (page 4)**

8. If it is primarily FFS and Substantially MCO requires clarification – additionally is not consistent with previous paragraph statement “the system offers little comprehensive care coordination”. -- What responsibilities are currently in the MCO’s contract regarding coordination of BH services rendered on a FFS basis?
- a. While most Medicaid recipients in NYS are in managed care for physical health, behavioral health services for many people are paid fee-for-service directly by the State. As shown in Table 2 of the draft waiver amendment, for some people (almost all BH services are carved out for the SSI population), the Plans pay for inpatient psychiatric services, detox, mental health clinic, and substance use clinic services. This represents a small part of the overall behavioral health spend.
  - b. For the neediest individuals with behavioral health conditions, the Plans have had little to no care coordination responsibilities for behavioral health services.
9. What is the timeline for MCOs and HARPs to ensure adequate capabilities activity and detail?

- a. NYS will have all services available by initial implementation with an approach to expand and build capacity for 1915(i)-like services. A readiness review will begin 4 months prior to implementation to ensure readiness.
10. Need more information on the proposed BH MLR—is this based on historical BH spending and plans must ensure that they spend on BH. This will act as a floor and a ceiling
  - a. The minimum medical loss ratio in MCOs will apply to Behavioral Health services only.
  - b. The minimum medical loss ratio in HARPs will encompass both Behavioral Health and Physical Health.
  - c. Medical loss will be determined as a percentage of the gross premium, less any withhold by the state for “stop loss” or other general “risk mitigation” pools, and in future years amounts reserved for quality incentives. The non-medical provisions of the premium include administration, profit, taxes (as applicable). Medical loss will be determined as a percentage of premiums, net of an allowance for administration, profit and taxes.
  - d. The calculation methodology for verifying medical loss will be provided as part of the financial reporting templates and instructions prescribed by the State after contract award.
  - e. If the Plan underspends relative to the required medical loss ratio, the difference will be rebated to NYS.
11. Isn't the BH capitation rate within a BH/PH premium and unsure how this overlays with health home reimbursement (admin support with balance to HH, sub-capitated arrangement, risk sharing arrangement?)
  - a. The BH capitation in mainstream plan is a defined increase to the current capitation rate to account for the cost of the new services moving into managed care.
  - b. Currently the Health Home reimbursement is a pass-through from the managed care plans to the Health Homes with approximately a maximum of 3% kept for Plan admin support. Plans and Health Homes may also negotiate a higher percent depending upon additional activities performed by the Plans for Health Homes. NYS is considering alternate reimbursement methodologies starting January 2015.
12. Please provide the estimated amount of time that it will take for network requirements/enhancements, increased capacity and expansion of service array to be reached.
  - a. NYS will have all services available by initial implementation. A readiness review will begin 4 months prior to implementation to ensure readiness.

13. Please provide examples of network requirements.
- a. MCOs/HARPs will be required to contract with Behavioral Health agencies licensed or certified by OMH or OASAS who currently serve five or more Medicaid managed care enrolled beneficiaries. MCOs/HARPs must contract with these current behavioral health agencies for at least the first 24 months of operation so long as quality of care is monitored and maintained consistent with 42 CFR 438.230(b)(4).
  - b. MCOs/HARPs will be required to contract with and maintain contracts with NY State determined essential community Behavioral Health providers (at this time these include State operated behavioral health programs) so long as quality of care is monitored and maintained consistent with 42 CFR 438.230(b)(4).
  - c. MCOs/HARPs will be required to contract with all Opioid Treatment programs in their service area (see Table 3) to ensure regional access and patient choice where possible so long as quality of care is monitored and maintained consistent with 42 CFR 438.230(b)(4).
  - d. MCOs/HARPs will be required to contract with OASAS residential programs and pay their allied clinical service providers on a single case or contracted basis for members who are placed in an OASAS certified residential programs to ensure continuity of care for patients placed outside of the MCO/HARP's service area.
  - e. Both HARPs and MCOs are required to contract with Health Homes under the State's approved Health Home SPA. All HARP enrollees will be enrolled in Health Homes and the Health Home will serve as the care manager for all services including the home and community based services provided under the 1915(i)-like authority. If an eligible individual does not have a selected Health Home, the Plan will work with the individual to select a Health Home. HARP enrollees will not be required to change Health Homes at the time of the transition. After the 2 year transition period, Plans will be required to contract as indicated in Table 3. HARPs will be required to pay on a single case basis for individuals enrolled in a Health Home at the time of transition when the Health Home is not under contract with the HARP.
  - f. All MCOs/HARPs will be required to contract with an adequate number of behavioral health clinic providers that offer urgent and non-urgent same day services.
  - g. The Plan will be required to contract with crisis service providers and require that they respond to referrals 24 hours per day, 7 days per week, 365 days per year, as of the contract start date. Plans will monitor the performance of crisis providers, including tracking and reporting response time, utilization and

cost by provider and opportunities for diversion or step down to lower levels of care that were delayed or missed due to the need for community-based alternatives.

14. Will the state issue a standard tool for routine screenings or will each MCO develop one?
    - a. The State will work with the Plans to develop standardized screening instruments for behavioral health needs in primary care.
  15. What data will be utilized to facilitate productive modeling?
    - a. The State will work with the Plans to develop effective methods for predictive modeling. The draft RFQ contains the following text on page 51  
*“The Plan shall implement programs to manage complex and high-cost, co-occurring BH and medical conditions that include the following elements:
      - a. Identification processes, including claims-based analyses and predictive modeling to identify high risk members”*
16. Will the state be monitoring for consistency across plans if they are using different service criteria?
  - a. Please see page 47 of the attached draft RFQ. The document states among other things that:
    - i. The Plan shall develop and implement Behavioral Health-specific UM protocols, including policies and procedures (P&Ps) and level of care guidelines that comply with the following requirements:
    - ii. UM protocols and level of care guidelines shall be specific to NYS levels of care and consistent with the State's medical necessity criteria and guidance.
    - iii. OASAS will identify the LOC guidelines that all Plans must use for Substance Use Disorder services. The LOCADTR tool will be used for making prior authorization and continuing care decisions for all Substance Use Disorder services.
    - iv. UM protocols and guidelines as well as any subsequent modifications to the protocols and guidelines shall be submitted to the State for prior review and approval.
17. Will the state be monitoring for consistency across plans if they are using different service criteria?
  - a. The Plan shall establish prior authorization and concurrent review protocols that comport with NYS Medicaid medical necessity standards.

- b. UM protocols and guidelines as well as any subsequent modifications to the protocols and guidelines shall be submitted to the State for prior review and approval.
18. What is the readiness review process for MCOs? -- How will the state determine subcontractor compliance and MCO oversight of subcontractors?
- a. New York State is in the process of developing the readiness review process for MCOs and will share this with CMS as soon as possible.

**Specialty BH Care for Special Populations (page 6)**

19. Will any participants currently receiving services lose eligibility due to the new protocols under the transition?
- a. No participants will lose eligibility for Medicaid under this transition.
  - b. If this question was meant to address services eligibility no members will lose eligibility for any services as a result of this transition.
20. What is meant by a full benefit HARP?
- a. See the answer to question 3 above.

**Program Components (page 7)**

21. Please explain enrollments into HARPs, beneficiaries in a mainstream plan be passively enrolled into that plan's HARP and can to disenroll to choose another HARP with a different MCO. How would that arrangement (beneficiaries in mainstream MCO and HARP within a different mainstream MCO) promote integrated care?
- a. Members are not enrolled in a mainstream plan and a HARP at the same time. As stated in question 3, the HARP is a distinct and specialized line of business offering the full range of physical health, behavioral health and pharmacy benefits for members that meet HARP eligibility criteria. Additionally, the HARP leadership team must include individuals with prior experience overseeing Behavioral Health managed care or clinical programs and all individuals enrolled in the HARP will be enrolled in a Health Home. The Health Home care manager will work with the HARP member to create an integrated person-centered plan of care.
  - b. A key goal in this managed care design is to avoid disrupting access to physical health care for individuals already enrolled in a mainstream Plan. Therefore, individuals initially identified as HARP eligible who are already enrolled in an MCO with a HARP will be passively enrolled in that Plan's HARP. The HARP network will include all of the same physical health providers as its mainstream Plan. This will ensure that Plan members will

continue to have access to the same network of physical health services as the new Behavioral Health benefits are brought into the Plan.

- c. As part of the passive enrollment process, individuals passively enrolled in a HARP will be informed about HARP benefits as well as their ability to stay in their existing mainstream Plan or chose another HARP.

22. Are these targeting criteria of enrollment of participants under a 1915(i) or HH?

- a. The targeting criteria listed in the October 30 draft 1115 waiver (page 14) are for HARP eligibility. All individuals in the HARP will be separately evaluated for eligibility for 1915(i)-like services.

23. Is the need-based a separate criterion? Are these two different requirements? They mention 3 above

- a. The needs based criteria are for access to the new enhanced array 1915(i)-like home and community based services. They are in addition to any targeting and risk factors required for HARP eligibility. The enhanced array of home and community services are for HARP enrolled individuals who meet both targeting and risk factors, as well as needs-based criteria for functional limitations.

**Table 1: Program Description Initiatives by Geographical Area**

24. Explain how “HARPS which are separate lines of business in qualified mainstream MCOs” is operationalized. Are they separate and independent? (Also see question 9 Above)

- a. HARPs are not independent corporations. They are a distinct and specialized line of business within a Plan with a separate capitation rate for HARP eligible members . HARPs offer the full range of physical health, behavioral health and pharmacy benefits. Additionally, the HARP leadership team must include individuals with prior experience overseeing Behavioral Health managed care or clinical programs and all individuals enrolled in the HARP will be enrolled in a Health Home. The Health Home care manager will work with the HARP member to create an integrated person-centered plan of care.
- b. Additionally, throughout Section 3 of the attached draft RFQ, supplemental HARP requirements exist in such areas as staffing, utilization management, clinical management, benefits (including 1915(i)-like services) and networks.

25. Will the beneficiaries have separate ID cards for the physical health and behavioral health components of coverage?

- a. One Plan identification card will be required.

26. Please describe the interaction between the HARPs and the Health Homes in terms of patient interaction, responsibility for service delivery and reimbursement for services in a manner that avoids duplication of payment for services rendered.

- a. HARPs are risk bearing health insurance plans. They create networks, conduct utilization management, monitor performance, and pay claims. Under federal law, Health Homes have 6 key functions including comprehensive care management and care coordination for individuals with chronic health conditions. Health home care managers work with high need individuals to develop individualized comprehensive plans of care. HARPs have review and approval responsibility for individual plans of care. In sum, Health homes provide face to face member care planning and care coordination and the HARP plan develops the services network, facilitates access to needed care and provides data and other support to the Health Home to assist.

27. Could a MCO have a qualifying HARP if they subcontracted? Has the state considered HARPs outside of the MCOs?

- a. Plans must qualify to manage the behavioral health benefits moving into managed care (mainstream plans and HARPs). Because some MCOs may not have the expertise to manage specialty BH benefits, MCOs will need to demonstrate their qualifications, partner with experienced vendors or providers or subcontract with a BH organization that meets the qualifications in the draft RFQ.
- b. To become a HARP, the Plan must have been operating as a Medicaid MCO in NYS as of March 1, 2013 and on the start-up date.

28. Timeframe for submission of SUD care SPA – Already here?

- a. OASAS will submit the SUD SPA at the same time as the 1115 is formally submitted.

29. We are pleased that the resolution of issues identified in several SPAs, currently off-the-clock, will be addressed prior to the approval of this amendment.

**Mainstream MCOs: Inclusion of BH services for Adults in the Mainstream MCOs Currently Under the 1115 Demonstration (page 7)**

**- Eligibility Requirement**

30. Serving people in ICF/IID in MCO others Outside of this amendment?

- a. While DD individuals can currently elect to enroll in mainstream managed care, they will not be eligible to enroll in HARPs. Once the OPWDD Developmental Disabilities Individual Care and Support Organization (DISCO) managed care plans are implemented, they will all be enrolled in DISCOs.

31. It is unclear who comprises special populations. Please identify the special populations and clarify if any participants are in state custody, i.e. foster care, juvenile justice, or corrections. Adding a chart describing the groups served (and excluded), the organizations providing services to each group and services included in the plan would be helpful to the reviewer. Perhaps Table 2 could be enhanced.
- a. See question 5 above. Special populations refers to:
    - i. Transition Age Youth who have participated in BH programs and HCBS waivers from either OMH or the Office of Children and Family Services.
    - ii. Individuals identified as having “First Episode Psychosis” (FEP).
  - b. Mainstream MCOs must work with these individuals to help them transition to HARPs as appropriate.
  - c. These individuals could be receiving services from a range of OMH, OASAS, OCFS, or State Education funded providers and/or Medicaid services.
32. MCOs screen children for access to their own separate line of business. Self-referral to higher level of care issues? Choice of HARPs? Is HARP benefit eligible for enhanced rate?
- a. HARPs are for Medicaid only (non-Medicare-Medicaid duals) adults 21 and over. Children are not enrolled in HARPs.
  - b. MCOs can identify potential HARP eligibles but determinations of eligibility are made by the State or a State approved independent entity.
  - c. The HARP eligibility criteria are defined on page 13 and 14 of the October 30 draft 1115 waiver.
  - d. The initial population for HARPs will be identified by New York State based on these criteria.
  - e. HARPs will receive an actuarially calculated capitation per member per month.
  - f. Members will have a choice of HARPs serving their area except that in a rural area, per 42 CFR 412.62(f)(1)(ii), there may only be one HARP available.
33. “Individuals identified as having “First Episode Psychosis” (FEP) will be enrolled in HARPs and be eligible for 1915(i)-like services through the HARP” seems inconsistent with “individual’s choice” above. Please explain.
- a. Individuals may always decline to be enrolled in a HARP or may choose to enroll in another HARP where available.
  - b. As part of the passive enrollment process, individuals passively enrolled in a HARP will be informed about HARP benefits as well as their ability to stay in their existing mainstream Plan or chose another HARP.

34. Dual eligible – outside this amendment -- Nursing Facility and Home and Community- Based Waiver participants – outside this amendment -- Monitoring of transitions to NF needs to be considered – Olmstead settlement indicates many individuals with BH needs in NF. BIP spending plan has pool of funds to increase transitional services but mainstream MCOs would not be serving these individuals before discharge.
- a. The BH amendment is but one component of a major Medicaid transformation in NYS. Individuals who are dually eligible are served under Managed Long Term Care Plans and the FIDA initiative are not targeted as part of this Behavioral Health waiver amendment. FIDA Health Plans serving “Duals” will contract with OASAS/OMH providers so that BH services may be provided. FIDA contract requirements are being aligned with the standards articulated in this 1115 and RFQ.
35. Please clarify the Medicaid covered services in the state plan and list in the amendment.
- a. Please see Table 2 on page 10 of the proposed amendment - *Benefits in Mainstream MCOs for all Medicaid Populations over the age of 20.*

### **Benefits and Cost-Sharing**

36. Do Medicaid FFS providers currently bill on a FFS basis or do they receive block funds? How many MCOs may these providers have to sign contracts with and learn how to bill?
- a. Medicaid FFS providers currently bill the State directly on a FFS basis for Medicaid covered services. Many also bill Medicaid managed care. As many services are currently carved out of managed care, some Medicaid FFS providers do not have contracts with Medicaid managed care companies and will need to develop them. The state is working with our health plan associations and behavioral health provider associations to facilitate local contracting conversations.
  - b. Most providers will need to sign contracts with a small number of Medicaid managed care Plans. The largest number of contracts a provider may need to sign is 8 (In NYC).
37. What are the appointment time standards? What are the distance/travel time standards for NY?
- a. The current Medicaid model contract states that “The Contractor will maintain a network that is geographically accessible to the population to be served.” For primary care it establishes a standard of 30 minutes/30 miles.
  - b. Proposed behavioral health appointment availability standards are identified in Table 4 of the attached draft RFQ (page 40).

38. At this time, the state plan lacks clarity about the mental health, substance use treatment and related services.
- a. We are unclear what this question is specifically asking for. We assume the responses to the other questions should cover this.
39. “During the term of the contract, the MCOs may provide services that are cost effective alternative treatment services and programs for enrolled members under 42 CFR 438.6(e)” -- In addition to the 1915i like services or are these 1915i services?
- a. NYS has not submitted a 1915i SPA as a result of the DRA of 2005, but will be seeking CMS approval for 1915i-like services under the authority of the 1115 waiver. These can be provided to eligible individuals enrolled in the HARP.
  - b. Mainstream Plans may provide cost effective alternative services that may include services similar the 1915i-like services provided by the HARP.
40. Please describe how the readiness review tool will be utilized in further detail.
- a. This tool is under development
41. Please provide a list of services that are to remain fee-for-service in the first year. Will all the qualified participants have access to those services?
- a. All SPA services will remain available in FFS. This is critical for individuals dually eligible for Medicaid and Medicare but will also be available to other populations ineligible for mainstream managed care and the HARP.
  - b. Rehab services for residents of community residence will remain FFS for individuals enrolled in Medicaid managed care during the first year of implementation. They will then be phased in.
  - c. All qualified beneficiaries will be able to access Medicaid services that continue to be claimed FFS if the service is not also covered under Medicaid managed care.

**Table 2. Benefits in Mainstream MCOs for all Medicaid Populations over the age of 20**

42. “PROS” Is this service described in the narrative?
- a. PROS is referenced in Table 2 in the draft 1115 and defined in the State Plan. Regulations can be found at <http://weblinks.westlaw.com/toc/default.aspx?Abbr=NY-CRR-F&Action=ExpandTree&AP=IC5487D50B7EC11DD9120824EAC0FFCCE&ItemKey=IC5487D50B7EC11DD9120824EAC0FFCCE&RP=%2Ftoc%2Fdefault.wl&Service=TOC&RS=WEBL13.10&VR=2.0&SPa=nyccr-1000&pbcc=DA010192&fragment#IC5487D50B7EC11DD9120824EAC0FFCCE>
43. “ACT” Is this service described in the narrative?
- a. ACT is referenced in Table 2 in the draft 1115 and defined in the State Plan. Regulations can be found at <http://weblinks.westlaw.com/toc/default.aspx?Abbr=NY-CRR-F&Action=ExpandTree&AP=IC511DCF0B7EC11DD9120824EAC0FFCCE&ItemKey=IC511DCF0B7EC11DD9120824EAC0FFCCE>

44. “Rehabilitation services for residential SUD treatment supports” -- Describe. Assure these services are not subject to the payment exclusion for institutions for mental disease (IMDs).
- The benefit package and the rates are constructed excluding IMD facilities.
  - Rehabilitation services will include clinical and medical services to individuals in residential SUD facilities; excluding room and board costs. All residential rehabilitation support services under this BH Waiver amendment are not subject to the payment exclusion for institutions for mental disease
45. “Rehabilitation services for residents of community residences” Describe. Assure these services are not subject to the payment exclusion for institutions for mental disease (IMDs).
- These are Medicaid rehabilitation services provided to recipients residing in community residences. They are designed to facilitate community integration or reintegration. Examples include training in and assistance with daily living skills, medication management, and socialization; substance abuse services; and parenting training.
  - Funds for these services are excluded from managed care rates for the first year of implementation. There are no community residential facilities in this program with greater than 16 beds.

### **Delivery System and Payment Rates for Services**

46. Describe what the requirements will be to qualify as a provider network.  
Are CMS requirements met?
- See provider network requirements described in question #13. Also see 3.5 through 3.7 in the draft RFQ.
47. Transition of FFS recipients to qualified MCOs – Must they have HARP capabilities – line of business to be qualified?
- No, Plans do not need to create a HARP. However, MCOs must qualify to provide BH services on their own or through a partnership with a behavioral health organization or experienced provider network.
48. When is this assessment made about the MCO’s ability to have the line of business or subcontract with an MBHO?
- NYS will make this assessment as a result of reviewing responses to the NYS Behavioral Health Request for Qualification (RFQ). The planned timeframe for Plan designation is in June 2014.

- b. HARPs will be a new line of business for Plans irrespective of whether the plan contracts with a BHO or not.
49. Will the providers in the MCO be licensed by OMH, OCFS and/or OASAS?
- a. Yes, the State Plan services providers are licensed by OASAS and OMH. 1915c waiver providers are authorized by OMH and OCFS. The State will be developing a process to designate or approve new 1915i services providers.
50. How will the state structure such incentives and penalties that there is ROI?
- a. The rates will be actuarially sound and will include a provision for underwriting gain.
51. “after 90 days, the MCO may apply utilization review criteria to individuals under the care of non-participating providers.” Please clarify this statement.
- a. The RFQ has a minor change from the draft 1115 waiver. The RFQ (section 3.7) now says “For continuity of care purposes Plans must allow members to continue with their care provider for the current episode of care. Plans may use acceptable UM protocols to review duration and intensity of this episode of care. This requirement will be in place for the first 24 months of the contract. It applies only to episodes of care that were ongoing during the transition period from FFS to managed care.”
52. “NYS anticipates that MCOs will be required to pay FFS rates to current outpatient behavioral health providers for the first 24 months of operation” -- Is the reimbursement strategy different for post 24 months? If so, what is this?
- a. After the 24 month period, plans and providers may negotiate alternative rate arrangements.

**Health and Recovery Plans (Harps): (page 13)**

The HARP scope of benefits is comprehensive and includes all State Plan Services as well as 1915(i)-like Home and Community Based services.

**- Eligibility, Enrollment, and Benefits**

53. Will HARP lines of business receive an additional capitation payment? How will these new services be priced to develop a capitation rate?
- a. HARPs will receive an actuarially calculated capitation per member per month. It will reflect all services to be provided.
54. MCOs will assess transition from mainstream MCO to HARP – Is there a separate/independent enrollment process.
- a. As stated in Section 1.9 of the draft RFQ “individuals initially identified as HARP eligible who are already enrolled in an MCO with a HARP will be passively enrolled in that Plan's HARP. This will ensure that Plan members

will continue to have access to the same network of physical health services as the new BH benefits are brought into the Plan.

- i. Plans with a HARP line of business will auto-enroll State rostered individuals in their HARP.
  - ii. As part of the passive enrollment process, these individuals will be informed about HARP benefits as well as their ability to stay in their existing mainstream Plan or chose another HARP.”
- b. Individuals presenting with serious functional deficits not identified by NYS as HARP eligible via historical risk factors may be identified by various service systems or service providers and referred to an independent enrollment broker for determination of HARP eligibility through either:
- i. A case review of individual's usage history to determine if Target Criteria and Risk Factors are met; or
  - ii. Completion of HARP eligibility screen.

55. If not provided otherwise, please include a section that defines benefits and who would receive the benefits.

- a. See table 2 in the draft 1115 waiver for a list of BH State Plan Medicaid benefits to be offered to adults in mainstream Plans. Table 3 lists the enhanced benefits to be offered in a HARP. Eligibility for the mainstream BH benefits is based on medical necessity determinations. Eligibility for the enhanced HCBS services in the HARP is based on a functional assessment and a person centered plan of care. See section 1.8 of the draft RFQ for more information on access to HCBS services.

56. MPF/HH - This should read ....”Health Home and” HCBS requirements...assuming the Health Homes meet CMS requirements.

- a. NYS’ will change the language on page 13 of the draft waiver to read “HARPs, operating within the MCOs as separate lines of business, will contract with the Health Homes and ensure that all Health Home and HCBS requirements and assurances are met.

**- Eligibility Requirement for HARP and 1915(1)-like**

57. Will state have oversight of transitions to HARPs when identified in by Plan’s review.

- a. Yes, these processes are being developed.

58. Can providers do serious functional deficits screen?

- a. Providers cannot complete eligibility assessments but they can refer people to an independent entity to determine HARP eligibility.
- b. To establish the eligibility for 1915(i)-like services, Health Homes will complete a functional assessment of all individuals who are enrolled in a

HARP. Firewalls will be established to ensure the assessment is completed in a conflict free manner.

59. HARP eligibility is performed by whom?
- a. NYS has determined through historical data that in year 1, approximately 140,000 individuals will meet HARP criteria and will be passively enrolled into HARPs statewide.
  - b. NYS or an independent entity will perform a conflict free HARP eligibility determination.
60. Nursing facility exclusion not mentioned in the HARP targeting criteria definition?
- a. Individuals in Nursing homes will be receiving their benefits either through Mainstream Managed Care plans, or MLTC Plans.
61. Where will the OPWDD population get the MH services?
- a. While DD individuals can currently elect to enroll in mainstream managed care, they will not be eligible to enroll in HARPs. Once the OPWDD Developmental Disabilities Individual Care and Support Organization (DISCO) managed care plans are implemented, they will all be enrolled in DISCOs.
62. *“Meets the HARP eligibility screen criteria that at least includes the needs-based criteria for 1915(i)-like eligibility”* -- Why are they referring to these as 1915i-like — what is the advantage -- how it’s handled in BN for the 1115. Can’t call them “I” if not authorized thru an “I”.
- a. The reference to “1915(i)-like” throughout the waiver application is used simply to describe the new populations and services that are similar to a 1915(i) state plan population/service package. However, NY is pursuing 1115 authority (rather than the 1915(i) itself) for the coverage of these new populations and services because of our need for additional authority to waive freedom of choice. Similar to how states and CMS have used “217-like”, “at-risk” or “TEFRA-like” terms in other 1115 waivers (for example), NY is adopting the term “1915(i)-like” to clarify the population and services described.
  - b. Specifically, for individuals who meet both the targeting/risk factors and the needs-based criteria, these “1915(i)-like” individuals will be eligible for an HCBS package of services. Because these individuals are already enrolled in mainstream MCOs and will be enrolled in HARP lines of business under the mainstream MCOs, New York needed to ensure that the state obtained waiver authority under the existing 1115 for freedom of choice which already authorizes the mainstream MCO program. The term “1915(i)-like” is further used for the state’s clarity in discussing this new program with its stakeholders because these services and populations could be covered under a 1915(i) SPA if the 1115 demonstration authority were not necessary in

addition to the 1915(i). Other states have also referred to these populations as “at-risk” populations eligible for HCBS under the 1115. The individuals do not meet an institutional level of care and for that reason, the state is not utilizing 1915(c)-like authority under the 1115.

63. What does “organized” MH service mean?

- a. An “organized” MH service is one which is licensed by the NYS Office of Mental Health.

64. Please define PMHP services. Once the recipient is enrolled in the MCO, will PMHP services continue?

- a. PMHP is a voluntary mental health only prepaid capitation plan offered by the NYS Office of Mental Health for individuals who elect OMH to be the provider of all ambulatory mental health service requirements.
- b. See question 1 above as the PMHP will not continue for members transitioned to the new benefit structure.

65. Clarify if “*residents in OMH funded housing*” includes individuals residing in housing of more than 16 beds and subject to the IMD payment exclusion.

- a. HARP enrollment is not being offered to individuals residing in facilities subject to the IMD exclusion.

66. Please clarify how children under age 21 would receive mental health or substance use disorder treatment under this demonstration. A “*history of involvement in children’s services*” appears to target or narrow access to medically necessary services for other children.

- a. As stated previously, HARPs serve individuals 21 and over. One of several risk factors for entry into the HARP includes transitioning into the adult system with a history of involvement in children’s services (e.g., RTF, HCBS, B2H waiver, RSSY).”
- b. NYS is developing a plan for moving children’s behavioral health services into managed care. This plan is about one year later than the plan for adults. As mentioned on page 5 of the draft waiver amendment request, the anticipated implementation date for children is January 2016.
- c. However, starting in 2015, Plans will be expected to provide behavioral health transition planning to ensure continuity of care for youth until age 23 or until the youth is stabilized in the adult system, whichever is later. MCOs must ensure that children who utilize BH programs and HCBS waivers from both OMH or the Office of Children and Family Services are screened for entry into a HARP and are transitioned to a HARP if that is the individual’s choice.
- d. MCOs will also need to provide the full range of medically necessary Medicaid services for members who have a first onset of psychosis.

Individuals identified as having “First Episode Psychosis” (FEP) will be enrolled in HARPs (if that is their choice) and be eligible for 1915(i)-like services through the HARP.

67. Services identified in the BIP spending plan are 1915(i) not (i) like. Please discuss the difference between BIP work plan and this designation. -- can't call them (i) services in an 1115
- a. Please see the response to question 62 for why we are using the term “1915(i)-like.” We recognize that these are technically 1115 services that will be eligible for enhanced match under BIP as Community-based LTSS provided under an 1115 demonstration and appreciate the opportunity to clarify this issue.
68. “*conflict-free evaluation/assessment* “ -- Describe this statement in more detail. How will NY meet the BIP design elements for the assessment, determination of eligibility and provision of service requirements? Indicate how screening for HARP access is conflict-free.
- a. HARP enrollment screening will be done by an independent entity.
  - b. Health Homes will perform the functional assessment for the 1915(i) like services and person centered plans of care. Firewalls will be put into place to prevent conflicts.
  - c. HARPs will review and approve person centered plans of care.

**- Benefits**

69. Please list, perhaps in Appendix A, the Medicaid State Plan services available to participants. In addition, please clarify these services in the State plan.
- a. See Appendix 1 of this document for service descriptions.
70. “*Health Home care manager (or other qualified individual)*” -- Credentials? Training.
- a. All individuals enrolled in the HARP will be enrolled in a Health Home. They will work with a Health Home care manager to develop a person-centered plan of care. However, the interRai assessment tool for the evaluation for 1915(i)-like needs based eligibility must be administered by a trained Health Home care manager or another trained Health Home staff member.
  - b. To ensure that this process complies with conflict free requirements, the Care Manager will offer the individual a choice of Plan network providers for all services included in their plan of care. Service options will be documented by the Care Manager and the plan of care will be reviewed and approved by the HARP pursuant to agreements between the Health Home and the HARP. The State and the HARP will implement audit protocols to ensure that choice was provided and considered in the selection of providers.

71. *“This will include the completion of an evaluation for 1915(i)-like needs based eligibility. This process will comply with federal conflict-free case management requirements.”* -- How? – Please provide more information.
- a. All individuals enrolled in the HARP will be enrolled in a Health Home. They will work with a Health Home care manager to develop a person-centered plan of care. However, the interRai assessment tool for the evaluation for 1915(i)-like needs based eligibility must be administered by a trained Health Home care manager or another trained Health Home staff member.
  - b. To ensure that this process complies with conflict free requirements, the Care Manager will offer the individual a choice of Plan network providers for all services included in their plan of care. Service options will be documented by the Care Manager and the plan of care will be reviewed and approved by the HARP. The State and the HARP will implement audit protocols to ensure that choice was provided and considered in the selection of providers.
72. *What* is the expected caseload of the care manager?
- a. Health Home caseload will be fluid based on the individual’s needs as identified in a person centered plan of care. We anticipate three tiers of payment and caseload based on the recipient’s needs.
73. *Regarding* footnote 7: clarify language to indicate that “individuals transitioning” only include individuals released from a correctional facility.
- a. This question actually refers to footnote 8, which refers to individuals transitioning from criminal justice involvement. Transitioning does not include people who are incarcerated and we will revise the footnote to make this clear.
74. *“Screening, monitoring, and outreach efforts will be used to ensure engagement in services and successful diversion and/or transition from criminal justice to community-based services”* -- Needs more discussion to ensure we don’t have inmate policy issues here.
- a. NYS can discuss in detail during the follow up call.

**- Table 3: HCBS Services for Adults Meeting Targeting and Functional Needs**

75. *Would* like to hear more about whom they intent to provide hab services for— descriptions don’t seem very recovery focused.
- a. Habilitation services are limited to Residential Supports services and are designed to assist participants with a mental health and/or substance use disorder or co-occurring diagnosis with acquiring, retaining, and improving skills such as communication, self-help, domestic, self-care, socialization, fine and gross motor skills, mobility, personal adjustment, relationship

development, use of community resources and adaptive skills necessary to reside successfully in home and community based settings.

76. Request they consider IPS model (transitional employment is fairly old school).

- a. NYS has integrated core elements of the IPS model into transitional employment service.
- b. NYS is reviewing the IPS model and CMS bulletin 9/16/11

77. *“New York will work to design and pilot test an initial individual prospective budget system”*-- What will this look like? More detail needed.

- a. New York will clarify the 1115 waiver. There are two objectives discussed in this section
  - i. A pilot on self-directed care. New York will phase in self-direction of 1915(i)-like HCBS services (based on the results of a pilot) over a 3 year period in this waiver. Supports for self-direction are included in the benefit package under this 1115 amendment and operationalization of those supports will be tested in a pilot.
  - ii. Revising the limits on 1915(i)-like services if needed based on actual experience. Generally as NYS gets experience in the utilization of the 1915i like services it may be necessary to adjust the initial service limits proposed. The adjustment will be based partially on the experience obtained from the administration of the interRai functional assessment tool.

78. What’s the difference between 1915(i)-like and 1915(i)-like “enhanced services”?

- a. There is no difference. The term enhanced just reflects that the HARP will offer an enhanced set of services. The text will be clarified.

### **Implementation of the Demonstration (page 20)**

79. How will NY determine the qualifications of MCOs and HARPs? How will qualifications be evaluated?

- a. Mainstream managed care Plans will need to demonstrate their qualifications to manage Medicaid behavioral health benefits. The proposed qualifications are identified in Section 3 of the attached draft RFQ.
- b. The behavioral health administrative and fiscal standards are identified in the attached draft RFQ in section 3. Staffing standards can be found in section 3.3. Network requirements are in Sections 3.5 and 3.6. Utilization management and clinical management are sections 3.9 and 3.10 respectively. Fiscal standards are identified 3.14, 3.16 and 3.17.
- c. This is a draft waiver amendment and the attached RFQ is part of a request for information. The State is currently working on evaluation criteria.

However, this is not a competitive bid. All Plans can qualify to manage the behavioral health services and all Plans can qualify to operate a HARP.

**List of Proposed Waivers and Expenditure Authorities (page 21)**

80. It appears that the demonstration would target certain special populations. Is a waiver of comparability needed?
- a. A request for a waiver of Comparability will be submitted with the final 1115 waiver. See page 22 of the waiver document.

**Public Process and Notice**

81. Please provide the exact date that this amendment was placed on public notice.
- a. November 27, 2013

**Appendix A**

**HCBS Service Definitions for HAPRs (page 23)**

82. It appears that parameters associated with services under 1915(i) or 1915(c) services would apply. Please confirm. It is unclear that these definitions would be consistent with section 1905(a) categories.
- a. Yes the parameters would apply in the context of providing the HCBS services under an 1115 waiver. These benefits are outside of the 1905(a) categories of service.
83. Please include the provider qualifications and certifications, licensing and other credentialing that is necessary in order to provide the HARP service.
- a. This is currently being developed and will be forwarded to CMS upon completion.
84. Please list the job titles/positions (e.g., psychiatrists, mental health therapy aides, social workers, nurses, etc.) that can render each service type.
- a. This is currently being developed. NYS will forward when available.

*Psychosocial Rehabilitation: (page 23)*

85. Are any of these services (psychosocial rehabilitation) offered through the state plan? And if so, what is different to ensure there is no duplication?
- a. None of the proposed HCBS services are offered as a separate SPA service in New York. PROS includes components of psychosocial rehab as a part of its program. The HCBS services are based on SAMHSA identified evidence based practices and offered in a person centered manner.

**- Crisis Intervention (page 25)**

*Mobile Crisis Intervention:*

Definitions:

- “*CI services are provided to a person who is experiencing a psychiatric crisis, are designed to interrupt and/or ameliorate a crisis experience including a preliminary assessment, immediate crisis resolution and de-escalation. The goals of CIs are engagement, symptom reduction, stabilization and. All activities must occur within the context of a potential or actual psychiatric crisis. CI is a face-to-face intervention and can occur in a variety of locations, including an emergency room or clinic setting, or other community locations where the person lives, works, attends school, and/or socializes. CI services include the following components:*”

86. Is there something missing here?

- a. The sentence should read: “The goals of CIs are symptom reduction, stabilization, and restoration to a previous level of functioning“. We will revise document.

**- Habilitation (page 27)**

87. Suggest breaking out transportation and describing parameters, since it is unclear what rules apply under the habilitation category.

- a. Agreed. This will be addressed in the official 1115 waiver submission.

**- Residential Supports/Supported Housing (page 27)**

88. Res supports will need to comply with HCBS characteristics

- a. Correct, these supports will only be provided in housing that meets the definition of a community based setting.

**- Respite (page 28)**

*Short-term Crisis Respite:*

89. Would this ever be provided in home?

- a. It is possible that this intervention could be provided in an individual’s home.

90. Please define the settings in which this service will be implemented. If it is delivered in a home in the community, the home must meet HCBS settings characteristics

- a. This is a short term (about 7 days) peer/ para-professional service. It can be delivered in a variety of locations, if it is delivered in an individual’s home, the home will meet HCBS requirements.

*Intensive Crisis Respite:*

91. Having a challenge comporting 45 days of crisis with intensive crisis—either the crisis is resolved in a matter of days or a week or it’s not.

- a. The 45 day limit is over the course of a year and not intended to be a single episode of care.

92. What are the characteristics and size of these facilities?
- a. Crisis residences are not permanent residences but short term crisis treatment and stabilization settings with stays not to exceed 7 days.
  - b. The State is still developing the standards.
93. Please define the settings in which this service will be implemented. If it is delivered in a home in the community, the home must meet HCBS settings characteristics.
- a. Agreed. We will provide additional clarification.
  - b. The State is still developing the standards.

**- Support Services (page 30)**

*Non-Medical Transportation*

94. What methods does the state have in place to ensure there is no duplicate billing for people receiving residential services, where transportation is included as part of the service?
- a. Non-Medical Transportation will be included as a part of an individual's plan of care. 1915i non-medical transportation will not be used when other appropriate transportation is provided through a state plan service received by the individual.

*Individual Employment Support Services*

95. Please cover SE as defined in the IPS model—
- a. NYS will consider the Individual Placement and Support (IPS) model in the design.
  - b. NYS OMH funds the Center for Practice Innovation out of Columbia University, the employment focus of this technical assistance center follows the evidence based approach of IPS. The center will be used to advance the IPS approach statewide.
96. The definition "*Individual Employment Support Services*" needs to cross-walked with the CMS IB issued on 9/16/11 related to employment supports to ensure the definition comports.
- a. NYS will ensure that the definitions comport.
97. "The outcome of this service is sustained paid employment at or above minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals." Informational Bulletin 9/16/11.
- a. NYS will ensure that the definitions comport.

**Services Included: (page 32)**

*“Services that provide learning and work experiences where the individual can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings”*

98. Should this be paid?

- a. Yes, we will correct this in the official 1115 submission.

*Transitional Employment:*

99. Not clear what the difference is between this service and supported employment.

- a. The difference between TEP and SE is that in TEP the job is targeted to be a short-term series of work experiences to help the individual gain experience and choose what type of work he or she may want to pursue for the long-term. The TEP jobs are typically filled by the NFP agency with a number of different candidates over time. This approach is part of the clubhouse model and will only be permitted in clubhouse settings.
- b. SE is a program that supports job search and job placement in integrated and competitive employment opportunities. The job is considered long term and SE program provides MH supports to assist the person to be successful in maintaining the position.

*Intensive Supported Employment:*

100. Please clarify the difference between the different levels of supported employment.

Does a participant have to move through each phase of SE before a person lands a job or could the person go directly into ongoing supported employment?

- a. Intensive Supported Employment services are based on the Individual Placement and Support (IPS) Model. Characteristics of IPS are integrated into our definition and we will be adding additional elements to maintain fidelity to the IPS Model."
- b. An individual will have a personalized plan of care based on their abilities and skills. Individual can progress to ongoing supported employment without going through each phase of SE.

**- Education Support Services (page 35)**

101. Must also provide an assurance that such services are not available through the community college, university or entity to the extent that they are offered to other individuals with a disability. Waiver services can cover “supports” to attend classes, but not the cost of tuition or books.

- a. Agreed, NYS will clarify this in the official 1115 submission..

102. Vocational training is not a Medicaid coverable service.

- a. NYS will be providing 1915i pre-vocational services.

103. In addition, FFP may not be claimed for services included in the child’s IEP.

a. Agreed

104. What is the difference between this service and Education Support Services?

a. Please clarify question.

**- Self-Directed Services (page 35)**

105. This sounds like language pulled out of a paper? Should be NY specific.

a. The language is based on a review of state self-directed care programs for intellectual disabilities populations. Self-directed care has not been widely used with MH and SUD populations. The intent of the pilot is to gather the necessary experience and information needed to establish a New York specific behavioral health self-directed care program. NYS will work with stakeholders including peer run organizations and managed care plans to design and pilot this initiative.

106. These services need to be much more detailed in terms of a service definition.

a. NYS OPWDD has experience in providing self-directed services for the I/DD population. We will use “lessons learned” and tailor to the BH population.

# **Appendix 1: Mental Health and Substance Use Service Descriptions**

Eligibility Criteria	Admission	Services
<p><b><u>Clinic Services:</u></b></p> <p>Eligibility for admission shall be based on a designated mental illness diagnosis.</p>	<p>Admission must occur within the first three visits. A screening and admission note must include the following:</p> <p>(1) reason for referral;</p> <p>(2) primary clinical and service-related needs and services to meet those needs; and</p> <p>(3) admission diagnosis.</p>	<p>A clinic treatment program shall provide treatment designed to reduce symptoms, to improve functioning, and to provide ongoing support. There are 10 required services and 5 optional services.</p> <p><b><u>Required Services:</u></b></p> <p>Assessment:</p> <ol style="list-style-type: none"> <li>1. Initial assessment</li> <li>2. Psychiatric assessment</li> </ol> <p>Therapies:</p> <ol style="list-style-type: none"> <li>3. Psychotherapy- individual</li> <li>4. Psychotherapy- family/collateral</li> <li>5. Psychotherapy- group</li> <li>6. Psychotropic medication treatment</li> <li>7. Psychotropic medication administration- injectable (for clinics serving adults)</li> </ol> <p>Enhanced Services:</p> <ol style="list-style-type: none"> <li>8. Crisis Intervention</li> <li>9. Complex care management</li> <li>10. Outreach</li> </ol> <p><b><u>Optional Services:</u></b></p> <ol style="list-style-type: none"> <li>1. Developmental testing</li> <li>2. Psychological testing</li> <li>3. Psychiatric consultation</li> <li>4. Health physicals</li> <li>5. Health monitoring</li> </ol>

Eligibility Criteria	Admission	Services
<p><b><u>Continuing Day Treatment Program:</u></b></p> <p>Eligibility for admission shall be based on a designated mental illness diagnosis and a dysfunction due to mental illness.</p>	<p>Admission shall occur within the first three visits. A screening and admission note must include the following:</p> <p>(1) reason for referral;</p> <p>(2) primary clinical and service-related needs and services to meet those needs; and</p> <p>(3) admission diagnosis.</p>	<p>A continuing day treatment program shall provide active treatment designed to maintain or enhance current levels of functioning and skills, to maintain community living, and to develop self-awareness and self-esteem through the exploration and development of strengths and interests.</p> <p>A continuing day treatment program shall provide:</p> <ul style="list-style-type: none"> <li>• assessment services</li> <li>• health screening services</li> <li>• treatment and discharge planning</li> </ul> <p>Required Services:</p> <ul style="list-style-type: none"> <li>• medication therapy;</li> <li>• medication education;</li> <li>• case management;</li> <li>• health referral;</li> <li>• rehabilitation readiness development;</li> <li>• psychiatric rehabilitation readiness determination and referral; and</li> <li>• symptom management.</li> </ul> <p>Optional Services:</p> <ul style="list-style-type: none"> <li>• supportive skills training;</li> <li>• activity therapy;</li> <li>• verbal therapy;</li> <li>• crisis intervention services; and</li> <li>• clinical support services.</li> </ul>

Eligibility Criteria	Admission	Services
<p><b><u>Partial Hospitalization Program:</u></b></p> <p>Eligibility for admission shall be based on a designated mental illness diagnosis which has resulted in dysfunction due to acute symptomatology requiring medically supervised intervention to achieve stabilization, without which, would necessitate admission to or continued stay in an inpatient hospital.</p>	<p>Admission shall occur within the first three visits. A screening and admission note must include the following:</p> <p>(1) reason for referral;</p> <p>(2) primary clinical and service-related needs and services to meet those needs; and</p> <p>(3) admission diagnosis.</p>	<p>A partial hospitalization program shall provide active treatment designed to stabilize and ameliorate acute symptoms, to serve as an alternative to inpatient hospitalization, or to reduce the length of a hospital stay within a medically supervised program.</p> <p>A partial hospitalization program shall provide:</p> <ul style="list-style-type: none"> <li>• assessment services</li> <li>• health screening services</li> <li>• treatment and discharge planning</li> </ul> <p>Required Services:</p> <ul style="list-style-type: none"> <li>• health referral;</li> <li>• symptom management;</li> <li>• medication therapy;</li> <li>• medication education;</li> <li>• verbal therapy;</li> <li>• case management;</li> <li>• psychiatric rehabilitation readiness determination and referral;</li> <li>• crisis intervention services;</li> <li>• activity therapy; and</li> <li>• clinical support services.</li> </ul>

Eligibility Criteria	Admission	Services
<p><b><u>Intensive Psychiatric Rehabilitation Treatment Program (IPRT):</u></b></p> <p>Eligibility for admission to an IPRT program shall be based on: 1) a designated mental illness diagnosis; 2) a dysfunction due to mental illness which is likely to continue for a prolonged time; 3) readiness to participate in a designated intensive psychiatric rehabilitation treatment program; and 4) referral by a licensed practitioner.</p>	<p>Admission shall occur within the first three visits. A screening and admission note must be written upon decision to admit which shall include the following:</p> <p>(1) reason for referral;</p> <p>(2) primary needs and rehabilitation aspirations;</p> <p>(3) admission diagnosis; and</p> <p>(4) results of a psychiatric rehabilitation readiness determination.</p>	<p>An intensive psychiatric rehabilitation treatment program is time limited, with active psychiatric rehabilitation designed to assist persons in forming and achieving mutually agreed upon goals in living, learning, working and social environments, to intervene with psychiatric rehabilitation technologies to overcome functional disabilities, and to improve environmental supports.</p> <p>An IPRT program shall provide:</p> <ul style="list-style-type: none"> <li>• assessment services</li> <li>• health screening services</li> <li>• treatment and discharge planning</li> </ul> <p>Required Services:</p> <ul style="list-style-type: none"> <li>• psychiatric rehabilitation readiness determination;</li> <li>• psychiatric rehabilitation goal setting;</li> <li>• psychiatric rehabilitation functional and resource assessment;</li> <li>• psychiatric rehabilitation skills and resource development; and</li> <li>• psychiatric rehabilitation support services.</li> </ul>

Eligibility Criteria	Admission	Services
<p><b><u>Personalized Recovery Oriented Services (PROS):</u></b></p> <p>Eligibility for admission is targeted for individuals with severe and persistent mental illness.</p>	<p>A screening and admission note shall be written upon a decision to admit and shall include the following:</p> <ol style="list-style-type: none"> <li>1. Reason for admission;</li> <li>2. Primary service-related needs and services to meet those needs; and</li> <li>3. Designated mental illness diagnosis.</li> </ol> <p>Recommendation for admission must be received by a licensed practitioner of the healing arts</p>	<p>PROS services are designed to assist individuals in recovery from the disabling effects of mental illness through the coordinated delivery of a customized array of rehabilitation, treatment and support services. Such services are expected to be available both in traditional program settings and in off-site locations where such individuals live, learn, work or socialize. The goal of the program is to integrate treatment, support, and rehabilitation in a manner that facilitates the individual's recovery.</p> <p>Services:</p> <ul style="list-style-type: none"> <li>• <i>Community Rehabilitation and Support (CRS)</i>: designed to engage and assist individuals in managing their illness and in restoring those skills and supports necessary to live in the community.</li> <li>• <i>Intensive Rehabilitation (IR)</i>: designed to intensively assist individuals in attaining specific life roles such as those related to competitive employment, independent housing and school.</li> <li>• <i>Ongoing Rehabilitation and Support (ORS)</i>: designed to assist individuals in managing symptoms and overcoming functional impairments as they integrate into a competitive workplace. VS interventions focus on supporting individuals in maintaining competitive integrated employment. Such services are provided off-site.</li> <li>• <i>Clinical Treatment</i>: designed to help stabilize, ameliorate and control an individual's symptoms of mental illness. Clinical Treatment interventions are expected to be highly integrated into the support and rehabilitation focus of the PROS program.</li> </ul>

Eligibility Criteria	Admission	Services
<p><b><u>Assertive Community Treatment (ACT):</u></b></p> <p>Individuals served by ACT have a serious and persistent psychiatric disorder and a treatment history that has been characterized by frequent use of psychiatric hospitalization and emergency rooms, involvement with the criminal justice system, alcohol/ substance abuse, and lack of engagement in traditional outpatient services.</p>	<p>Each local department of community mental health services has established a single point of access process (SPOA) for receiving and processing referrals for services, matching individuals to the services that they need, triaging access so that those most in need get priority access. The population served by ACT comprises a small subset of persons with serious mental illness.</p>	<p>ACT is a mobile team based approach to delivering comprehensive and flexible treatment, rehabilitation, case management and support services. ACT is distinguished from more traditional case management by several important features. First, rather than a case manager coordinating services, an ACT multi-disciplinary team provides services directly to an individual that are tailored to meet his/her specific needs. An ACT team typically includes members from one of the fields of psychiatry, nursing, psychology, and social work with increasing involvement of substance abuse and vocational rehabilitation specialists. Based on their various areas of expertise, the team members collaborate to deliver integrated services of the recipients' choice, monitor progress towards goals, and adjust services over time to meet the recipient's changing needs.</p> <p>Services:</p> <ul style="list-style-type: none"> <li>• ACT teams deliver comprehensive and flexible treatment, support, and rehabilitation services to individuals in their natural living settings</li> </ul>

Eligibility Criteria	Admission	Services
<p><b><u>CPEP Services:</u></b></p> <p>CPEPs provide emergency observation, evaluation, care, and treatment in a safe and comfortable environment for those individuals alleged to have a mental illness.</p>	<p>No person is involuntarily retained in a CPEP for more than 24 hours unless the person is admitted to an Extended Observation Bed.</p> <p>The CPEP can retain in an Extended Observation Bed any person alleged to have a mental illness which is likely to result in serious harm to the person or others and for whom immediate observation, care, and treatment in the program is appropriate. Retention does not exceed 72 hours, which is calculated from the time the person is initially received into the CPEP ER.</p>	<p>CPEPs are designed to directly provide or ensure the provision of a full range of psychiatric emergency services, seven days a week, for a defined geographic area. The four required components of service are:</p> <ul style="list-style-type: none"> <li>• <i>Hospital-based crisis intervention services</i> in the emergency room, including triage, referral, and psychiatric and medical evaluations and assessments;</li> <li>• <i>Extended observation beds</i> in the hospital to provide for extended evaluation, assessment, or stabilization of acute psychiatric symptoms for up to 72 hours;</li> <li>• <i>Crisis outreach services</i> in the community, including clinical assessment and crisis intervention treatment; and</li> <li>• <i>Crisis residence services</i> in the community for temporary residential and other necessary support services for up to five consecutive days.</li> </ul>

## Inpatient Services

Inpatient Services provide stabilization and intensive treatment and rehabilitation with 24-hour care in a controlled environment. They are the programs of choice only when the required services and supports cannot be delivered in community settings.

- Inpatient Psychiatric Unit of a General Hospital: A licensed, 24 hr. inpatient treatment program that is jointly licensed by the New York State Office of Mental Health and the New York State Department of Health and operated in a medical hospital. Includes full-time medical, psychiatric and social services and around-the-clock nursing services for individuals with mental illness.
- Private Psychiatric Hospital / Hospital for Mentally Ill: 24-hour inpatient treatment program that is licensed by the New York State Office of Mental Health and operates in private hospitals that provide behavioral health services exclusively.
- Residential Treatment Facility - Children & Youth: Residential Treatment Facilities (RTF's) provide fully-integrated mental health treatment services to seriously emotionally disturbed children and youth between the ages of five and 21 years of age. These services are provided in 14-61 bed facilities which are certified by both the Office of Mental Health (OMH) and the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) or Council on Accreditation (COA). RTF's are less intensively staffed than inpatient units, but provide a much higher level of services and staffing than community residences, Office of Children and Family Services (formerly the Department of Social Services) group homes, and/or child care institutions.
- State Psychiatric Center Inpatient: 24-hour psychiatric inpatient treatment program that is operated by the New York State Office of Mental Health.

## Community Support Services

**Health Home Care Management:** The OMH Home Care Management will track programs and slot capacity for former OMH Targeted Case Management (TCM) programs that converted into Health Home Care Management under the Health Home entity.

Health Home Care Managers support the provision of coordinated, comprehensive medical and behavioral health care to Medicaid-enrolled adults with chronic conditions through care management. The goal of care management is to: assure access to appropriate services; improve health outcomes; reduce preventable hospitalizations and emergency room visits; promote the use of health information technology (HIT); and avoid unnecessary care.

In addition, Health Home Care Managers:

- Provide comprehensive care management, health promotion, transitional care including appropriate follow-up from inpatient to other settings, patient and family support, referral to community and social support services.
- Promote optimal health and wellness for adults diagnosed with severe mental illness. Attain wellness and recovery goals by implementing a person-centered approach to service delivery and ensuring linkages to and coordination of essential community resources

Substance Use Service Type	Admission	Services
Crisis Services :  LOCADTR/ASAM  Medically Managed Medically Supervised	Clients have significant symptoms of withdrawal that require 24 hour medical monitoring and intervention in order to safely detoxify from substances.	Medical and Clinical interventions to reduce symptoms of withdrawal through medication management / identification and management of cravings and urges to use.  Linkage to next level of care
LOCADTR – Outpatient, ASAM level I	<ul style="list-style-type: none"> <li>• Patient is not in need of emergency or crisis services based on LOCADTR assessment of need;</li> <li>• Patient meets the criteria for a diagnosis of SUD based on DSM criteria;</li> <li>• Patient does not meet medical; psychiatric; hazardous use or functional risk criteria for higher level of care and/or;</li> <li>• Patient has resources that are adequate to support care in an outpatient setting if risks are present;</li> <li>• Patient has housing that is adequate to support recovery in an outpatient setting.</li> </ul>	Outpatient programs provide a wide array of clinical services as specified in OASAS regulations through the use of Common Procedure coding including CPT, HCPCS and E/M service codes defined in the Ambulatory Patient Grouping Clinical and Billing Guidance Manual <a href="http://www.oasas.ny.gov/admin/hcf/APG/documents/APGManual.pdf">http://www.oasas.ny.gov/admin/hcf/APG/documents/APGManual.pdf</a>

<p>LOCADTR – Intensive Outpatient ASAM – level II.1</p>	<ul style="list-style-type: none"> <li>• Patient has a risk of substantial harm due to substance use in either mental health, physical or due to hazardous use of the substance or;</li> <li>• Patient has a risk of harm due to Significant deficits in personal or interpersonal skills and;</li> <li>• Patient has significant family or social support and;</li> <li>• Demonstrates functioning in work, social and family roles and;</li> <li>• Demonstrates ability to manage triggers to use in environment and</li> <li>• Patient has adequate safe housing to support recovery.</li> </ul>	<p>Services are provided in a minimum of 3 hour sessions at a minimum of 3 times per week for a minimum of 9 hours per week of clinical services provided in group, family and individual sessions.</p>
<p>LOCADTR – Day Rehabilitation/ ASAM II.1</p>	<ul style="list-style-type: none"> <li>• Patient has significant risks associated with SUD due to serious functional deficits and;</li> <li>• Psychiatric or medical conditions are manageable in an outpatient setting and;</li> <li>• Client has safe housing that is supportive of recovery goals.</li> </ul>	<p>Services include medical services by medical staff and psychiatrists including medication management. Clinical services are provided in group, individual and family sessions and are geared toward the development of pro-social behavioral and cognitive and behavioral interventions to promote the development of coping skills, and management of emotion, and increasing self-control to promote effective functioning in peer groups based on the pursuit of mutual goals.</p>

<p>LOCADTR – Inpatient/ ASAM level III.3</p>	<ul style="list-style-type: none"> <li>• Patient has significant risk due to medical, psychiatric or pattern of hazardous use that requires a 24 hour structured environment for treatment to be safe and effective and;</li>   <li>• Patient lacks social and environmental supports including functioning in responsible roles in community, family and social supports and ability to manage triggers to use in their environment</li> </ul>	<p>Care in a structured medically directed 24 hour secure facility. Services include medical treatment to stabilize SUD including mild withdrawal, cravings, and physical health conditions that co-occur. Psychiatric interventions to stabilize co-occurring mental health conditions or SUD related mood or anxiety symptoms. Clinical interventions to provide skill building to provide alternative coping skills, behavioral strategies for coping with cravings and urges to use substances, cognitive and behavioral interventions for increased coping with mood and anxiety symptoms, peer and mutual support through self- help and individual peer interactions.</p>
<p>LOCADTR – Services in Residential Setting (Stabilization) ASAM III.5*</p>	<ul style="list-style-type: none"> <li>• Patients demonstrate significant risks due to serious interpersonal and personal skills deficits and;</li>   <li>• They do not have significant history of violence and serious acts of manipulation leading to harm toward others and;</li>   <li>• They lack safe housing that would support attainment of functioning and remission of SUD in an outpatient stabilization and rehabilitation program and;</li> </ul>	<p>Patients in need of Services in a Residential Setting (Stabilization) demonstrate interpersonal and personal deficits in functioning in significant social and family roles and no safe housing option that supports recovery. Patients need a secure 24 hour setting overseen by medical staff and focused on the planned use of community to model and reinforce pro-social functioning but are not in need of 24 hour medical/nursing services. Patients have access to medical services for assessment of medical, SUD and psychiatric needs. Services are provided to address mild withdrawal and cravings through medication assisted recovery approaches, nursing support to provide safe self-medication oversight and psychiatric and medical treatment as needed per individualized assessment and treatment plan. Clinical interventions</p>

	<ul style="list-style-type: none"> <li>• They are in need of a structured 24 hour safe residential component in order to stabilize SUD symptoms including craving and skills to manage triggers and cravings to use in the community, medical and psychiatric symptoms</li> </ul>	include group and individual sessions to develop coping interpersonal skills, cognitive and behavioral interventions, trauma informed approached and treatment interventions, and other skills based practices to improve emotional and social functioning.
LOCATDR -Treatment Services in a Residential Setting (rehabilitative) / ASAM level III.3*	<ul style="list-style-type: none"> <li>• Medical and Psychiatric conditions, if present, are stable but need 24 hour structured environment to safely learn skills to manage triggers in the environment</li> <li>• Patients have deficits in social and emotional functioning</li> </ul>	Patients who are appropriate for services at this level of care have significant risks due to medical, psychiatric co-occurring disorders or serious risks due to a pattern of hazardous use of substances, or serious functional deficits that impair adequate personal and interpersonal functioning and lack safe housing options to support recovery. Medical and psychiatric conditions, if present, are stable but require ongoing treatment to support remission from SUD and long term management to support recovery goals. Services provided include medical services to manage ongoing medical and psychiatric conditions, nursing staff to provide safe oversight of self-medication practices and promotion of long-term self-care for chronic illnesses. Clinical interventions are provided in group, individual and families to promote management of symptoms, urges to use, social connectivity, peer and mutual support and cognitive and behavioral skills for improved management of mood and anxiety.
LOCADTR – Treatment Services in	<ul style="list-style-type: none"> <li>• Medical and Psychiatric</li> </ul>	Patients appropriate for this level of care have no

<p>Residential Setting (re-integration) ASAM III.1*</p>	<p>conditions, if present, are stable and able to be managed in an outpatient setting;</p> <ul style="list-style-type: none"> <li>• Patient has ability to connect to family and community resources including self and mutual help, clinical services, vocational and educational services, childcare and other supports within the community while managing triggers in the environment;</li> <li>• Patient lacks safe housing option that supports long-term recovery goals.</li> </ul>	<p>significant risks due to substance use and have the ability to connect to resources to support recovery. They lack safe housing supportive of supporting remission from SUD and supporting long-term recovery. The program has access to medical staff for oversight and nursing staff to support safe self-administration of medications and the development of self-care skills to manage chronic illness. Patients participate in all activities of daily living to promote transition to independent community living. Clinical staff support increasing independence through individual and group sessions limited to 5 hours a week or less on site. Patients access medical, psychiatric and SUD treatment in the community as needed.</p>
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\* OASAS Residential Services per SPA to be submitted